

## Public Burden Statement

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U.S. Department of Transportation  
Federal Motor Carrier  
Safety Administration

## Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined Last Name: Miller First Name: Clinton In accordance with (please check only one):

☒ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) OR

☐ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply):

☐ Wearing corrective lenses ☐ Accompanied by a \_\_\_\_\_ waiver/exemption ☐ Driving within an exempt intracity zone (49 CFR 391.62) (Federal)

☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 (Federal)

☐ Grandfathered from State requirements (State)

Medical Examiner's Certificate Expiration Date

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments, embodies my findings completely and correctly and is on file in my office.

5/29/24

Medical Examiner's Signature

Medical Examiner's Telephone Number

Date Certificate Signed

Medical Examiner's Name (please print or type)

☐ MD ☒ Physician Assistant ☐ Advanced Practice Nurse

☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) \_\_\_\_\_

Medical Examiner's State License, Certificate, or Registration Number

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

CLP/CDL Applicant/Holder

Street Address: 1812 Glenridge St City: Palm Bay State/Province: FL Zip Code: 32909 ☒ Yes ☐ No

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